DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 4/12/14

PRINTED: 02/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E232	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLEDSOE COUNTY NURSING HOME	107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to provide exits readily accessible at all times. The finding included: Observation on 2/24/14 at 10:16 AM revealed the exit discharge from the A and B Hall exits did not have all-weather hard surface to the public way. This was verified by the maintenance director and acknowledged by the facility administrator during the exit conference on 2/24/14.	K 038	**K 038** **1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICENT PRACTICE?** Maintenance/Safety Director is obtaining bids for pouring concrete walk to connect B Hall exit to public way. Project is anticipated to be completed by April 11, 2014. **2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** By connecting this all-weather hard surface to the public way, this will provide exits readily accessible at all times.	4/11/14
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Bryant
TITLE: Administrator
(X6) DATE: 3/13/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Stephanie Bryant

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K 066	Continued From page 1 (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to provide the required equipment in smoking areas. The finding included: Observation of the smoking area on 2/24/14 at 10:15 AM revealed there was no metal container with self-closing cover devices into which ashtrays can be emptied readily available to all areas where smoking is permitted. This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 2/24/14.	K 066	2) **HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Maintenance/Safety Director and staff will monitor smoking area to ensure metal container is readily available and ashtrays are emptied as needed. 3) **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?** Maintenance/Safety Director and staff will include monitoring of metal can with monthly safety inspection of fire extinguisher that is located in the smoking area.	

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